UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

QUALAQUIN (quinine sulfate)

Patient name:_____Medicaid or SS#_____
Physician Name:_____Contact person:_____
Phone#:_____Ext. and opt._____Fax#_____
Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO: 801-536-0477

CRITERIA:

- Minimum age requirement: 16 years old.
- Diagnosis of malaria.

AUTHORIZATION:

One 7 day course of up to 42 tablets is approved with each PA.

RE-AUTHORIZATION:

Same as initial PA.

02/17/2009